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ABSTRACT

This paper (1) summarizes some of the recent research and evaluation of drug and other substance abuse programs, and (2) directs attention to the work of Federal agencies (NIDA and ADAMHA) concerned with drug and substance abuse, with special reference to the impact of this work on the alleviation of minority group drug abuse problems. Evidence is presented to support the contention that the bulk of research on drug abuse fails to consider those social and economic factors that require different and more complex solutions for minority drug abuse problems. Commonalities and differences between majority and minority group drug abusers are explored. The differential access to information for minorities, due to lower school attendance and greater social isolation, is offered as one example of how current prevention models (relying on the strategies of information, education, alternatives, and intervention) fail to address minority needs. Other problems discussed are the lack of pertinent data on minority drug abuse and the irrelevance of existing information for the social worker trying to deal with drug abuse at the street level. Also criticized is the over-reliance on continuing formal evaluations and esoteric research of existing programs. Finally, it is held that political and socioeconomic factors should be the primary foci for minority drug abuse prevention.
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MULTICULTURAL APPROACHES IN ALCOHOL, DRUG ABUSE AND MENTAL HEALTH PREVENTION PROGRAMS

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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Remarks by Carolyn R. Payton, Director
Center for Multicultural Awareness

at

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EXECUTIVE SUMMARY

This paper summarizes some of the recent research and evaluation of drug and other substance abuse programs and directs attention to the work of NIDA and ADAMHA, with special reference to the possible impact of this work on efforts to alleviate drug abuse problems, particularly among ethnics of color. It is contended and supported that the bulk of research fails to include those socio-economic, those street factors, that make the solution more difficult, or at least different, for minorities. The admitted paucity of data on minorities in this research is attributed, in most cases, to sampling problems but the author contends that these are much less important than the street-wisdom and authority-avoidance that can very effectively skew the data.

Commonalities and differences are explored between majority and minority drug abusers, emphasizing differential access to vital information for the minorities. For example, the NIDA design classifies prevention programs into Information, Education, Alternatives and Intervention. The author submits that such a model addresses the majority and not the minority, pointing out that delayed education obstructs the flow of information, that low high school attendance allows the most vulnerable group to miss a most potent source of information, the classroom, and that housing and income-poverty are insufficiently considered,

thus obstructing the flow of assistance to be found through Alternatives and Intervention. Alienated groups will not be reached through conventional procedures based on samples derived primarily from majority groups.

Ethnic concerns about drug abuse prevention strategies are inadequately addressed at the national level and the focus on impact measures, evaluation procedures and requirements can be threatening to the uninitiated. Sophisticated evaluation techniques, however commendable regarding statistical significance and levels of confidence, are meaningless to the street worker who must spend time worrying about loss of funding, through lack of chi square, and not enough time addressing the goals and objectives in human terms. The taxpayer is certainly entitled to know how funds are being spent and how effective programs are; policy makers are, and should be, accountable. However, the methods by which this accounting is done need not fall into experimental designs and control groups more appropriate to rats than to human beings. The senior level managers of grants should be satisfied with "good evidence" that the programs are doing what they originally claimed could happen as a result of funding. There are many ways to accomplish this: informal, non-structured interviews, minutes of meetings, attendance at activities, body-counts if you will. Evaluations should not be viewed as obstacles, but rather as consultative elements of long-range assistance.

Finally, an effective multi-cultural approach to drug abuse and other substance abuse, including mental illness prevention, should incorporate recommendations made to the President's Commission by the Special Populations Subpanels--and without delay. Enough esoteric research has been done to request a moratorium on all further analytical studies until we know the results of the work and effort now in place.

INTRODUCTION

Ethnics of color who may have read position statements of the current administration might be encouraged, take heart, from the recognition given to the specific concerns of minorities in the fields of mental health, alcohol and drug abuse prevention programs. For example, the 1978 Policy Review on Drug Use Patterns, Consequences and the Federal Response devotes almost two pages to the topic of ethnic /sic/ Minorities. The 1979 Federal Strategy for Drug Abuse and Drug Traffic Prevention cites as one of the key elements of prevention, planning and developing materials for ethnic minorities. Dr. Helen Nowlis, in a statement prepared for the Select Committee on Narcotics Abuse and Control Hearings of May 1979, describes activities of the Office of Education which support programs tailored to the ethnic and demographic needs of communities. President Carter's Message to the Congress includes this statement: "Among some minority groups the incidence of addiction and the harm it inflicts are disproportionate." The Report to the President from the President's Commission on Mental Health also reflects attention paid to America's ethnic and racial populations and the need to take into account the different cultural traditions.

It would appear, then, that the Federal Government has sensed the suffering of minorities caused by substance abuse and other elements within the society and does, indeed, support action to reduce the resulting harm. However, trying to document

the actual extent of substance abuse or mental illness among minorities seems impossible.

Drug Use Patterns, Consequences and the Federal Response: A Policy Review, makes the following statement on the subject:

> "Assessing the drug abuse problem in ethnic minority communities is a complex and difficult task, in part because of the lack of research information and data on the nature of the drug problems of such groups."[1]

One wonders why this should continue to be true, given the resources of the Federal Government. There are those who regard with some suspicion the concluding sentence of the above quoted statement - "This has hampered efforts to make the drug programs and resources of the Federal Government available, accessible, sensitive and relevant to minority community concerns." Many minorities would assert that this relationship - lack of data and lack of resources - is deliberate. As long as the incidence and prevalance of mal-adaptive behavior is unknown, substantial misconceptions can develop and resources can be misallocated. The Institute for Social Research at the University of Michigan, under a research grant from the National Institute on Drug Abuse, has published a very extensive report dealing with drug use, attitudes about drug use, and the perceived availability of drugs among high school seniors in 1977. The authors cite as rationale for their survey the following:

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[1] Drug Use Patterns, Consequences and The Federal Response: A Policy Review. Office of Drug Abuse Policy, Executive Office of the President, March 1978, p. 35.

-- Accurate assessment of size and contours of the problem of illicit drug use among young Americans is important for public debate and policymaking.

-- Reliable trend data permits assessment of the impact of major historical and policy induced events.

-- Reliable trend data will help in early detection and localization of emerging problems.[2]

These are quite laudable objectives and are equally desirable for minority youth. However, the data presented are analyzed by sex, college plans, region of the country, and population density or urbanicity, but not ethnicity. A rather curious omission.

No doubt the explanation for the omission is the usual - "The sample used for most surveys do not provide enough cases for a reliable assessment of the status of minority groups."

The 1977 National Survey on Drug Abuse[3] does break out some of its data in terms of whites and nonwhites. But such displays are little better than useless, as drug usage varies within groups and between groups and ranking of drugs in terms of perceived harm differs by groups. The aggregation of all ethnic groups into one statistic can be misleading because the statistics tend to obscure the very real differences among ethnic groups. Such figures can lead to false inferences and counterproductive policies and actions.

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[2] Drug Use Among American High School Students: 1975-1977, National Institute on Drug Abuse, U.S. Department of Health, Education & Welfare, Publication No. (ADM) 78-619, p.

[3] National Survey on Drug Abuse: 1977, National Institute on Drug Abuse, U.S. Department of Health, Education & Welfare, Publication No. (ADM) 78-618, 1977.

It is acknowledged that since minority populations are relatively small, compared to the majority, and are distributed geographically in diverse patterns, a larger sample than is commonly used is necessary to ensure adequate coverage of the minority populations. Although, increasingly, better and more timely statistical information is provided for blacks and Hispanic Americans, the largest minority groups, it is rare to find a statistical report that provides separate tabulations on such groups as American Indians, Chinese Americans, Japanese Americans, Mexican Americans, Cuban Americans and Puerto Ricans.

Most of our knowledge of drug usage among minorities is based on data from institutions and social agencies--hospitals, coroner's offices, police agencies, treatment programs--and represent counts of various critical events related to drug use. The Client Oriented Data Acquisition Process (CODAP) is illustrative of this tendency to provide statistical information on clients admitted to treatment in federally-funded clinics. The Drug Abuse Warning Network (DAWN) gathers drug abuse data from a sample of hospital emergency rooms, offices of medical examiners and County Coroners, and crisis intervention centers and also typifies sources used for drug information among minorities. Rarely, if ever, is assessment found of drug use on those segments of the minority population who do not come to the attention of these agencies. It is safe to assume that a significant proportion of this group have little or no contact with such agencies as listed.

The distortions that may result from employing such a limited sample is readily apparent. One hears, for example, that heroin-related death and emergency room visits (the drug most frequently linked in the public's mind with Blacks) is at an all time low. The conclusion is reached that the heroin problem is decreasing. Minorities interpret this to mean that funds for addressing this problem will also be decreasing. Minorities also recognize that heroin addicts may have learned to avoid those institutions which have provided the statistics originally. Thus the "reduction" may be but an artifact of street wisdom.

Information on the extent of mental disorders by race is also shaky. Kramer, Rosen and Willis[4] point out the inadequacy of statistics on this phenomenon. They too conclude that such data are needed to plan programs to eliminate the attitudes, practices, and conditions of life that affect so adversely the physical and mental health and social well-being of minorities and to allow evaluation of efforts to accomplish this goal.

This entire issue of factual data on minorities and mental disorders, abuse of drugs and alcohol, has been captured succinctly by Dr. Sue Stanley in a paper presented at the National Conference on Minority Group Alcohol, Drug Abuse and Mental Health Issues. She states:

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[4]M. Kramer, B. Rosen, and E. M. Willis, "Definitions and Distributions of Mental Disorders in a Racist Society," Racism and Mental Health, ed. C. Willie, Bernard Kramer, and Bertram Brown (Pittsburgh: University of Pittsburgh Press), 1973.

> First, in the stage of the status of ethnic minorities we need an increase in the quantity and quality of research studies. Because of methodological, conceptual, and practical problems in ethnic research we are still at the elementary steps in having systematic and accurate information on various ethnic groups. . . . We lack basic and essential information. For example, we still do not know how many Asians are in the U.S. Estimates vary from official sources to community leaders. The same situation exists for Mexican Americans. There is still a great deal of controversy over the rate and extent of mental disorders, drug abuse, and alcoholism among ethnic group individuals.[5]

Even if statistics describing drug use patterns and consequences among minorities are missing or are biased and inaccurate, these groups are as concerned with preventing drug abuse as the majority group. Primary prevention strategies, in general, have had a rocky history and this is no less true of prevention activities generated by or for members of minority communities. The May issue of the Monitor, the house organ of the American Psychological Association, in several articles reviews some of the criticism provoked by the advocation of prevention. Although the focus is primary prevention of mental disorders, the same criticism applies to drug and alcohol abuse prevention. Key points made were:

-- The time is not right for prevention as more research is needed on causal factors.

-- Efforts to intervene with healthy people to reduce the incidence of disorders is Utopian nonsense.

-- Is there a best way to deliver preventive services

-- Prevention is bad for the business of psychotherapists /and drug and alcohol treatment professionals/

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[5]Sue Stanley, "Ethnic Minority Research: Trends and Directions," paper presented at the National Conference on Minority Group Alcohol, Drug Abuse and Mental Health Issues, Denver, Col., May 1978, p. 7.

-- Where is the evidence that prevention makes a difference

However, a most convincing argument for supporting primary prevention is also made by George Albee in an editorial printed in the same issue of the Monitor. Dr. Albee states:

> In view of the lessons of history and present reality, it is paradoxical that the bulk of current health care is directed at treatment rather than prevention. There has been dramatic improvement in the overall health of a majority of Americans during this century, but this improvement has been the result of successful prevention through better nutrition, pest and pollution control,[6] vaccination and sanitation. . . .

The impetus that primary prevention is currently experiencing must be continued and advanced on both humanitarian and pragmatic grounds. Primary prevention models draw attention to the social context in which aberrant behaviors (mental disorders, drug and alcohol abuse) arise. Treatment allows the causal factors of such behavior to continue unmodified, to wreak damage over and over again.

COMMONALITIES AND DIFFERENCES

The national policy of primary prevention of drug abuse postulated by NIDA stresses the relationship of drug abuse by young people to personal and social development. Further, the NIDA design neatly categorizes possible prevention programs as: Information - Education - Alternatives and Intervention. Minority groups have no difficulty with this conceptualization and therein lies the commonalities between the dominant and

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[6] George Albee, "Preventing Prevention," APA Monitor, May 1979.

minority societies. Self actualization is certainly highly prized and valued by Blacks, Native Americans, Asians, Hispanics. Minorities would also agree that the various categories identified by NIDA can and do provide avenues for the development of self-esteem; the raising of levels of aspiration.

Nevertheless, minorities know that the prevention model defined by NIDA does not embrace elements significant to the groups. An inference which can be made from an analysis of the model is that if steps are taken to promote personal and social growth, barriers to reaching full individual potential will have been removed. This is simply not the case for minorities. All of the affective education, any amount of drug information (scary or not scary), values clarification or decision making/problem solving skills will not move one clod from the wall of the race related prison-enclosing minorities in this country. There cannot be an effective primary prevention drug abuse, alcohol abuse or mental disorder program for minorities which fails to deal with the reality of growing up as a minority in these United States. For policy makers to continue to believe and behave as though prejudice and racial oppression are insignificantly related to the drug problems of minorities is a farce. (The author is reminded here of an exchange between herself and a member of the U.S. diplomatic mission in a country abroad. The conversation occurred in the mid 60's and during the stirrings of the Civil Rights Movement. The gentleman, who happened to be white, and this writer, were holding forth on the subject of the unrest of

Blacks in the U.S. He in great sincerity suggested that whites could be more tolerant and accepting of blacks if "we would only clean up our streets." It is obvious that he and others like him cannot understand that if you are poor, ill-fed, ill-housed and under-served, cleaning up paper, bottles and other debris on the street may not be a very basic need. So it is with the national policy on primary prevention of drug abuse--peer and cross-age tutoring, role playing, outward bound activities--will not put one slice of bread on the table nor buy baby a new pair of shoes.

A review of the findings reported in the publication, Social Indicators of Equality for Minorities and Women,[7] documents the above position. Indicators are presented for different aspects of education, employment, income, and housing for men and women in the following groups: American Indians, Alaskan Natives, Blacks, Mexican Americans, Japanese Americans, Chinese Americans, Philipino Americans, and Puerto Ricans. The social indicators presented in the report provide clear documentation of many continuing and serious problems of inequality afflicting the groups studied. Some examples are:

Delayed Education.--In 1976 the percentage of women and minority men 2 or more years behind the average grade for their age was approximately twice the percentage for majority males. Most groups became relatively more delayed from 1970 to 1976, indicating increased inequality.

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[7] Social Indicators of Equality for Minorities and Women, A report of the United States Commission on Civil Rights, Washington, D. C., 1978.

The minority concern in the field of education is getting an education. The majority seem concerned with truancy and run-aways; minorities with push-outs, throw aways or being classified as mental retardates.

High School Non-Attendance.--Young people in some minority groups are at least twice as likely as majority males to be out of school at this important stage in their development.

The drug abuse professional for the dominant society stress health curricula or drug information which address drug issues in the school setting. The minority communities realize that this approach will allow a highly vulnerable and at-risk segment to go untouched and in ignorance of the consequences of drug abuse. A further note regarding the general effectiveness of information as a prevention strategy must be added. Vincent Myers'[8] work reveals that readily available and pertinent information about drugs has not been internalized among young minority groups. According to him, drug information materials are either written in standard English or Spanish which may not be attended to or understood by young people from oral and aural subcultures. These materials may also be presented in audio-visual forms in which minorities and other low income groups are excluded (e.g., Reading, Writing & Reefers). If the gaps in drug knowledge are to be closed, drug abuse information must be presented in forms which are suitable to the interest and experience of minorities.

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[8]Vincent Myers,"Drug Related Cognition Among Minority Youth," J. Drug Education, Vol. 7 (1), 1977, pp. 53-62.

They must be in forms to which they can easily relate.

Housing.--Minorities are more likely to live in central cities than the suburbs where majority headed households are found, less likely to be homeowners, more likely to live in overcrowded conditions, and more likely to spend more than a quarter of their family income on rent.

There are research findings which show that within the majority culture there is a strong possibility that children may be introduced to drug use by older brothers or sisters. Given the housing conditions just described it is probable, even more likely among minorities, that behavior of older sibs will be witnessed by and thus copied by younger children.

Income and Poverty.--Minorities are more likely to be unemployed (especially if they are teenagers), to have less prestigious occupations, and to be concentrated in different occupations than majority males. With regard to income, minorities have less per capita household income; lower earnings even after such determinants of earnings as education, weeks of work, age and occupation prestige have been adjusted for; smaller annual increases in earnings with age, and a greater likelihood of being in poverty.

Individuals experiencing these conditions are prone to respond with frustration, pain, powerlessness, lack of hope for change, and alienation. All of these have been identified as correlates of substance abuse activity--using substances to escape or dilute such feelings. Climbing Mt. Everest or rappeling

down the Grand Canyon may indeed be appropriate alternatives to drug usage by the bored teenager in Montgomery County, but is hardly an appropriate substitute to being poor - unemployed - underemployed.

Similar conclusions were reached by the Task Panel on Special Population of the President's Commission on Mental Health.[9] This Panel's views indicate the important linkage between psycho-social factors and healthy development.

> The primary avenue to reduction in prevalence and incidence of mental disorders in the Black (minority) community is not professional services to individuals but changes in society at multiple levels. Data suggest that a certain level of income, housing, employment, educational opportunity, health care, for example, are requisite conditions to the prevention and maintenance of optimism, positive self-esteem, and general mental health. Blacks (minorities) face specific problems at every point in the life cycle so that the greatest promise is in prevention programs keyed to needs at each phase.

Ethnic Concerns About Prevention Strategies.

Implicit in all the preceding has been ethnic concerns about national prevention policies and programs. There is one concern that needs specific highlighting. It arises out of the Institute's interpretation of the Federal Government's need for measures of the cost effectiveness of funded activities. It is the concern of minorities at prescribed impact measures or evaluation of programs. Minorities report that all too frequently program evaluation has meant a loss of program funding. Not because goals and objectives were not met, but because results were

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[9] Task Panel Reports Submitted to the President's Commission on Mental Health, Volume III Appendix (Washington, D.C.: Government Printing Office, 1978), p. 743.

were not expressed in terms of statistical significance or levels of confidence.

Congress has a need to know that tax payer's dollars are being spent wisely and for worthwhile causes. Our policy makers, however, are reasonable men and women. There are ways of documenting outcomes/program results that do not require employing an experimental design or control groups or random sampling that would be acceptable, it is believed, to the Congress.

The senior level managers who award grants and contracts should be satisfied with good evidence that the programs are doing what they originally claimed they would do. Sometimes this evidence may come from taped interviews of participants or relatives of participants. The evidence could be as simple as attendance records of recipients in a particular activity. The application of sophisticated statistical procedures does not make a good program better or a bad program worse. Minorities feel, in many instances, that prescribed evaluative techniques are simply one more obstacle put in the way of their receiving services.

At a recent workshop held in the District of Columbia for minority prevention professionals this latter perception was voiced most frequently. In essence, members were saying that they had been encouraged by getting program funds; pleased at having learned how to write proposals in language acceptable to funding agencies; satisfied at the progress being made and the goals and objectives achieved. Then when they felt they had

mastered the twists and turns of the funding maze, the rules were changed. Now programs would only be funded if an evaluation component were included. The evaluation component would be judged, it seemed, on the basis of level of sophistication. Never mind that service delivery would be interrupted, if not terminated. No matter that clients would be lost for lack of a regression equation--a coefficient of reliability. To receive funds, it seemed, it was necessary to administer the MMPI to Native Americans - Mexican Americans - Asian Americans - Blacks, Puerto Ricans - in pre and post test designs. To provide services, the criterion of need is second to the criterion of utilizing an identified, reliable and valid instrument. The intuitive rejection of prescribed evaluation strategies by minorities gains a measure of support from recent published statements of "experts" or "scholars."

Schulberg and Perloff took a look at the state of human service dlievery program evaluators. Some of their findings were:

-- The traditional source for program evaluators has been academically educated researchers who have learned to use experimental techniques and statistical analyses to investigate theoretical issues but rarely have acquired skills needed for improving service delivery.

-- Evaluators trained in experimental design, when required to assess services and suggest policy directions, may use methodologies and instruments better suited to controlled laboratories than a chaotic organization.

-- Untrained researchers faced with assessment of services may derive unwarranted conclusions from studies possessing neither internal nor external validity.

-- Most graduate programs use the research or clinical training models, neither of which is directly relevant to evaluation training.

-- Few academicians appreciate the conceptual and methodological differences between generating new knowledge and evaluating existing programs and innovations.

-- Evaluators must recognize the practical and conceptual implications of choosing among the amelioration, accountability, and advocacy program evaluation models and the ethical dilemmas contained in each.

-- Gathering data for program-specific decisions and for broad issues may require a variety of evaluative designs; e.g., case studies, quasi-experimental, legal adversarial approaches, etc.[10]

The next quote very accurately reflects the conclusions of minorities:

> Sound scientific study refers to the logic of design, observation/measurement, analysis and interpretation. But we must avoid the mistake of assuming that if a research tool is complicated, quantitative and esoteric it therefore must be sound. You buy complexity, quantification and precision at a cost in constraining assumptions, limits to generalizability and increases in artificiality.[11]

Just as minorities know the burden of oppression and racial discrimination without the assistance of measuring tools or evaluative research, they are also aware when this burden

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[10] Herbert C. Schulberg and Robert Perloff, "Academia and the Training of Human Service Delivery Program Evaluators," American Psychology, Vol. 34, #3, 1979, pp. 247-254.

[11] The Editor's Page, Journal of Social Issues, Vol. 35, #2, 1979.

has been lessened. The growth in self-esteem that comes with getting a job, knowing one's voice is heard. Being able to make demands may not be reflected on the Tennessee Self Concept Scale (which is irrelevant anyway to the individual who has discovered inherent strengths and ability).

Once again the different circumstances from which minorities and dominant members of the society operate need to be weighted to understand the different attitudes held toward evaluation. Given the rather obscure nature of stresses leading to drug abuse behavior among whites, there would have to be some urgency to discover which strategies best influence such behavior or which aspect of a given program influences which aspects of its recipient. It is reasoned here that the psycho-social stresses for minorities are blatantly apparent and the urgency is directed to alleviating these stresses. If it can be demonstrated that a program results in keeping children in schools, or in day care centers so that parents can work; in their homes rather than with foster care parents or in institutions; program activities provide young people with marketable skills; appreciation of their unique culture, value systems and beliefs, recognition and respect for survival skills - street smartness, then such programs would be viewed from the multi-cultural perspective as primary prevention.

Evaluative strategies must be considered within the context prescribed by Bush and Gordon:

> We have to decide in each particular case not only whose view more closely represents the situation but also who will be most affected by whatever service decision is made. The professional (evaluation specialist) who prevails over a client (program manager) for reasons no other than his/her possession of well tested knowledge has won an encounter for one version of the truth or less dramatically, for the professionals' right not to be unduly challenged or inconvenienced. The client who loses such a battle will have lost things the client considered vital to his/her well being.[12]

In short, the Ph.D., academically-trained researcher has been trained to appreciate a special way of defining truth. For a program manager to disagree with what is considered his/her specialty is annoying. When the expert disagrees with the program manager's perception of Truth, huamn wastage may result.

This is not an argument to do away with evaluation. It is a plea for appropriate recognition of the complexity of the primary prevention concept. As Caplan points out, the goals of prevention efforts are rarely single and simple, they are usually multiple and complex.[13] Problems of specifying and obtaining adequate controls are also difficult. What may seem to be objective data may be dependent on unseen and unstudied subjective factors of both recipient and families, and of professionals. The authors acknowledge that different methods of evaluation will be appropriate for different programs. In some cases, subjective reports by clients of increased self-confidence or decreased familial

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[12] Malcolm Bush and A. G. Gordon, "Choice and Accountability," Journal of Social Issues, Vol. 34, 4, 1978, p. 42.

[13] Gerald Caplan and Henry Grunebaum, "Perspectives on Primary Prevention," Arch. Gen. Psychiatry, Vol. 17, Sept. 1967, pp. 331-346.

discord will be appropriate; in other cases clinical judgment of the degree of personal growth and development or professional assessment of increase in I.Q; and for still others, lowered rates of homocides. To reiterate, from a multi-cultural perspective, counting the number of adolescents who have secured employment or for that matter, the number of eligible families who have been taught how to secure food stamps are valid indicators of the efficacy of primary prevention programming.

The writer adheres to the position that political-social factors, and not the individual minority member, are the primary foci for prevention programs. Equipping minorities with the wherewithal to successfully maneuver through a system which constantly rebuffs them is a germane goal for primary prevention programs.

Finally, awareness of ethnic's concerns in primary prevention can be drawn from previous conferences, workshops, task force meetings and the like. Anyone taking the pain to read the proceedings will find themes repeated in gathering after gathering. Some of these are listed:

Prevention Issues

Prevention, a service intervention strategy which has the potential for improving the health of all people in our society, has not been sufficiently supported by policy or funding. Racial minorities in particular are especially in need of additional community-based prevention programs. Therefore, it is recommended that:

1. The Alcohol, Drug, and Mental Health Administration (ADAMHA) develop a comprehensive list of racial minority prevention specialists to include: consultants, researchers, practitioners, and advisors who could contribute to the prevention strategy of ADAMHA.

2. ADAMHA and its Institutes immediately promote racial minority prevention programs which would:

   a. Develop preventive strategies relevant to socio-cultural factors for implementation by state, county, and local mental health programs;

   b. Develop prevention materials relevant to each particular racial minority community, appropriately designed in the languages and "dialects" of the various monolingual and bilingual racial minority communities.

   c. Develop training programs in prevention for treatment personnel based upon the conceptual theory and practical skills relevant to racial minority and socio-economically oppressed people; and

   d. Develop specific "coping/survival" skill curricula applicable to each racial minority group in primary and secondary education levels.

3. ADAMHA provide the Minority Advisory Committee with a report on the current status of ADAMHA's efforts to ensure relevant prevention for racial minorities.

4. ADAMHA initiate the drafting of legislation which would require ten percent of Community Mental Health Center (CMHC) funds to be utilized for primary prevention programs and public health strategies.[14]

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[14]National Conference on Minority Group Alcohol, Drug Abuse and Mental Health Issues. Conference Proceedings. May 22-24, 1978, Denver, Colorado.

The recommendations of the Minority Group Alcohol, Drug Abuse and Mental Health Issues' Conference have been presented verbatim. It is hoped that by continuing to emphasize these recommendations, additional movement toward achieving these objectives will be made.

A recent issue of the ADAMHA news quotes the ADAMHA administrator as stating that "the mental health field should confine its intervention to activities based on accepted concepts of public health, scientific evidence, and the profession's social mandate to perform specialized tasks."[15] Changing the societal context in which minorities live is clearly beyond the province of mental health services and providers. Advocacy within the mental health field can, however, lead the way toward improving the quality of the social milieu.

An effective multi-cultural approach to drug abuse, alcohol abuse and mental illness prevention must incorporate the recommendations made to the President's Commission on Mental Health by the Special Populations Subpanels on Health of Black Americans:

1. Full employment achieved through the initiatives of the public and private sectors, and equal access to jobs assured by the continuation of affirmative action legislation.
2. Affirmative action in the distribution of housing funds and opportunities for adequate housing.

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[15] ADAMHA News, Vol. V, #14, July 13, 1979, p. 1.

3. Redistribution of health care facilities, with particular attention to primary prevention, and (2) improving access to quality health care.
4. Implementation of public welfare services that concentrate on the elimination of poverty and which support and supplement the initiatives of individuals to be participants in American society.
5. Lack of professional health and social manpower is a serious problem for minorities. Strong emphasis must be placed on manpower and scholarship programs for minorities so that they can assume responsibility for their own destiny.

In conclusion, professionals in drug abuse prevention, particularly those who have focused on the problems of ethnics of color, will have found little new or particularly exciting in this paper. I have not tried to be conclusive, inclusive or comprehensive. I have tried to underscore the work that needs to be done. There are enough studies and surveys by well intentioned professionals of all persuasions for us now to put aside further "research" and get with the program; we know abuse exists, we know where it exists, we know among whom it exists, we know that universal panaceas exist but do not work and, finally, we know that implementation of the recommendations in this paper can be delayed no longer.

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